Physicians found themselves adrift and embattled with no good means to defend themselves, let alone to develop a workable and lasting solution to the problem. At that time practicing physicians decided to create a means or an instrument with which they could maneuver in the field of financing of patient care. They assumed the responsibility to make this instrument work and they supported it with their energy and substance. History records that Blue Shield has served the profession well through the years in many a difficult situation, and in spite of its ups and downs, Blue Shield continues to be supported by a still growing physician membership, now more than 18,000 in California alone.

Now, much as was the case 40 years ago, the malpractice issue has placed practicing physicians, particularly in California but elsewhere as well, in a situation where the private sector seems either unable or unwilling to cope with an insurance problem, and both physicians and their care of patients are profoundly affected. Again there are great pressures for some kind of governmental intervention, and again physicians find themselves with no adequate means or instrument with which to defend themselves or to develop a workable or lasting solution to what is primarily a social and economic problem in patient care.

Can the private sector do it? At the moment the answer appears to be in doubt, and it would seem that if the answer is to be in the affirmative, the initiative will have to come from somewhere within the health care industry. It is obvious that practicing physicians have the most at stake personally, both for themselves and their patients. If there is anything to be learned from history it would seem the time has now come for the profession to develop an instrument of its own in the field of professional liability insurance, one with which it can not only defend practicing physicians but set standards of quality and efficiency which others in the field will have to meet, and be prepared to support it with both energy and substance.

Time is running out. We cannot wait for the rest of the private sector to act, if indeed it ever will without leadership from private medicine. It is to be hoped that practicing physicians will soon find a way to assume the necessary leadership to do what needs to be done now. The alternatives are clear enough and they are right on our doorstep.

—MSMW

Routine Screening of Asymptomatic Women for Gonorrhea

ELSEWHERE IN THIS ISSUE of the JOURNAL appears a provocative paper by Dr. King K. Holmes on screening methods for detection of asymptomatic gonorrhea. Also in this issue is a sign, designed for display in an examining room, which states that most women who have gonorrhea do not know it and urges patients to "ask for a test."

Although Dr. Holmes disputes the frequency of asymptomatic gonorrhea in the female population, others have estimated that 80 to 90 percent of all women with gonorrhea have no symptoms sufficiently severe to alert them to the need for medical care, and hence do not seek examination and treatment. The United States Public Health Service (USPHS) is now funding a large scale program based on the premise that screening and treating asymptomatic women must become routine practice before the current epidemic of gonorrhea can be contained. The results of this nationwide, federal program are those presented in Table 1 of Holmes' paper.

During the calendar year 1974, more than 900,000 cases of gonorrhea were reported in the United States, but we know that countless others went unreported. Table 1 in Holmes' paper shows the USPHS statistics on the results of cultures from women screened for gonorrhea among various populations throughout the country. Of more than 2¼ million women tested in private physicians' offices, 1.9 percent were noted to have positive cultures. This is an impressive yield for any screening test, and, for example, far surpasses the yield from the Papanicolaou smear which is by now an accepted and standard procedure. Although untreated gonorrhea in women is not lethal, as cervical carcinoma may be, the morbidity in terms of pain, infertility and other complications can be severe. In addition, the spread of gonorrhea must be checked for reasons

of public health as well. The aim therefore is to urge those in the private sector of medicine to screen women routinely for asymptomatic gonorrhea.

The techniques used are of utmost importance. Cervical *smears* for gonorrhea screening in women are a waste of time because of poor sensitivity. Bacterial *culture* from a properly secured cervical specimen is the technique of choice. A rectal specimen taken at the same time further enhances the likelihood of identifying asymptomatic carriers.

There are various means of handling these specimens. In general, a modified Thayer-Martin culture plate incubated in a carbon dioxide enriched atmosphere at 35°C is required. One can use standard Petri dishes or smaller modifications. The culture can be sent to an outside laboratory or it can be incubated in a physician's office. Efficient and relatively inexpensive incubators are now available for such use in an office. The plates can be inspected by an office assistant at 48 hours and then tested with a very quick oxidase reagent procedure if colonies of appropriate morphology are noted. Further testing of the oxidase positive material with Gram stain can be done in a physician's office or in an outside laboratory. Sugar fermentation tests can be done to identify the organism more precisely. Another method is to place the specimen immediately in transport media which allows the otherwise relatively labile Neisseria gonorrhea bacteria to be sent to private or health department laboratories during early stages of incubation.

Some physicians would choose to treat a woman purely on the basis of the oxidase positive culture grown on the selective Thayer-Martin medium; some consider it more appropriate to wait for the results of the Gram stain, and some would insist that treatment wait until a diagnosis is made from the full spectrum of laboratory procedures. Under some circumstances, one may wish to repeat a culture that gave positive findings and send it to a clinical laboratory. One's choice in this matter would depend upon social and economic factors as well as upon scientific considerations.

Plates can be purchased and the screening culture test done for less than $1.00 per patient. The added cost of further testing that the physician might choose to do would apply to a very small proportion of the total population being screened. Government funds are available in some communities through local health departments to provide laboratory support for private physicians or clinics. Many local health departments also have trained staff members available to assist with instructions to physicians and their staffs in proper culture techniques.

We make the plea that each physician develop some fairly broad criteria for screening asymptomatic women for gonorrhea by bacterial culture so that this will become common practice.

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Is Obesity a Surgical Disease?

THE SPECTRUM OF ILLNESS which confronts us ranges from immediately life-threatening diseases which require bold intervention to cosmetic ailments which trouble primarily the psyche. Massive, often morbid obesity is at neither extreme of this spectrum, and yet it is an illness with potentially lethal complications. Scientists and insurance companies have addressed themselves to the question of where to draw the line between obesity as a disease and inconsequential fatness. We, as physicians, must wrestle with the issue of what posture we should take toward operations which have been devised to combat obesity. Are these operations currently therapeutic or investigational?

The factors and observations which support the operative treatment of obesity have been clearly delineated in recent years.[1,2] Therefore, either to list the positive features of the results from operations as reported by others, or to repeat the statistics of our personal experience, which has been recently reported in some detail[3] would be redundant. It has become abundantly clear that massively obese people who become lean as a result of jejunoileal bypass are usually highly satisfied. Their self-esteem is so enhanced that they gen-